Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 11-0541 BN
	)	
APRIL KOLASA,	)	
	)	
Respondent.	)	

DECISION

April Kolasa is not subject to discipline.

Procedure

On March 24, 2011, the State Board of Nursing ("the Board") filed a complaint seeking to discipline Kolasa. On April 6, 2011, we served Kolasa with a copy of the complaint and our notice of complaint/notice of hearing. Kolasa filed an answer on December 19, 2011. We held a hearing on September 18, 2012. Angela Marmion appeared for the Board. Kolasa appeared *pro se*.[1] The matter became ready for our decision on November 26, 2012, when the last written arguments were due.

Findings of Fact

1. Kolasa is licensed by the Board as a licensed practical nurse ("LPN") in the State of Missouri. Her Missouri nursing license is current and active and was so at all relevant times.

[1] Kolasa was represented by counsel between November 14, 2011, and April 4, 2011. Counsel withdrew on April 4, 2012.

2. Kolasa was employed as an LPN at Northland LTAC Hospital ("Northland")[2] at all times relevant to this action.

The tracheotomy incident

3. On October 26, 2008, a patient in Northland was on a home ventilator at night and a tracheotomy shield ("trach shield") and oxygen during the day. The ventilator is a life support system that attaches to the tracheotomy opening in the throat. The trach shield provides oxygen and humidity to the patient's air and goes around the neck and covers the tracheotomy opening during the day.

4. In order to place a trach shield on a patient, a person must remove the ventilator, turn on the oxygen, hook up the humidifier and tubing, and place the trach shield around the neck.

5. Hospital policy required that respiratory therapists remove ventilators from patients and place trach shields on patients.

6. On October 26, 2008, Kolasa was on duty. She was working with, among others, registered respiratory therapist Deneen Perry.

7. Perry was specifically trained to remove ventilators from, and place trach shields on, patients.

8. On the morning of October 26, 2008, Kolasa called Perry twice and informed her that the patient was ready to come off the ventilator and go on the trach shield.

9. Perry was the only respiratory therapist on duty that morning and did not respond quickly.

10. Perry told Kolasa that she would come down and switch the patient from the ventilator to the trach shield.

11. Before Perry arrived, the patient removed the tubes from the ventilator.

[2] Northland LATC Hospital is now known as Kindred Northland Hospital.

12. The patient's oxygen level dropped to 60%, and Kolasa was concerned that the patient might die.

13. Kolasa attached the trach shield to provide the patient the necessary oxygen.

14. When Perry arrived at the patient's room, the patient was already off the ventilator and had the trach shield on.

Patient T.D.

15. On October 26, 2008, Kolasa was assigned to care for patient T.D.

16. T.D. had an order for up to two tablets of 5/325 mg hydrocodone/APAP[3] every six hours as needed for pain.

17. A registered nurse administered 2 tablets of 5/325 mg hydrocodone/APAP to T.D. at 2:00 PM.

18. Kolasa administered 2 tablets of 5/325 mg hydrocodone/APAP to T.D. at 6:00 PM.[4]

19. Northland utilized an "automated dispensing system" for controlled substances known as "Med Dispense."

20. Kolasa retrieved two 5/325 tablets of hydrocodone from Med Dispense at 8:46 AM for patient T.D. Kolasa destroyed that medication.

21. Kolasa retrieved two 5/325 tablets of hydrocodone from Med Dispense at 12:40 PM for patient T.D. There is no record that Kolasa administered this medication to T.D. Kolasa destroyed that medication.

22. T.D. had an order for Dilantin 300mg.

23. Kolasa administered eight prescription cups (800 mg) of Dilantin to T.D. at 9:00 AM.

[3] Hydrocodone/APAP is hydrocodone with acetaminophen.

[4] Kolasa indicated on T.D.'s chart that she administered the hydrocodone/APAP at 5:30 PM. Pet. Ex. 1 at Ex. 3, page 1. The Med Dispense withdrawal sheets show that Kolasa withdrew the hydrocodone/APAP at 5:58 PM. Pet. Ex. 1 at Ex. 2, page 3. The Med Dispense system is an "automated dispensing system." Tr. 16. We choose to accept the machine results instead of Kolasa's handwritten entry.

Patient G.M.

24. On October 26, 2008, Kolasa was assigned to care for patient G.M.

25. Patient G.M. had an order for insulin. If G.M's blood glucose count was between 180 and 250, G.M. was to receive 4 units of insulin. If G.M's blood glucose count was above 251, she was to receive more insulin. G.M. was not to receive insulin if her blood glucose count was below 180.

26. At 5:00 PM, Kolasa took a blood sample from G.M.'s fingertip and determined that G.M.'s blood glucose level was 150.

27. At 6:00 PM, Kolasa administered four units of insulin to G.M.

Patient W.L.

28. On October 26, 2008, Kolasa was assigned to care for patient W.L.

29. At 8:30 AM, Kolasa withdrew one 50 mcg fentanyl patch from Med Dispense for W.L.

30. Kolasa applied the 50 mcg fentanyl patch to W.L. at 9:00 AM.

31. W.L. was ordered to receive a 25 mcg fentanyl patch.

32. Kolasa retrieved one 15 mg morphine tablet from Med Dispense at 8:29 AM for patient W.L. Kolasa destroyed this medicine.

33. Kolasa retrieved one 15 mg morphine tablet from Med Dispense at 6:14 PM for patient W.L. Kolasa destroyed this medicine.

Conclusions of Law

We have jurisdiction to hear the complaint.[5] The Board has the burden of proving that Kolasa has committed an act for which the law allows discipline.[6] The Board argues that there is cause for discipline under § 335.066.2:

[5] Section 621.045. Statutory references, unless otherwise noted, are to RSMo Supp. 2012.
[6] *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo.App .E.D. 1989).

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> (1) Use or unlawful possession of any controlled substance, as defined in Chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by sections 335.011to 335.096;
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> ***
>
> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
>
> ***
>
> (12) Violation of any professional trust or confidence;
>
> ***
>
> (14) Violation of the drug laws or rules and regulations of this state, any other state or the federal government[.]

Subsections (1) and (14) – Unlawful Drug Possession and Unlawful Drug Use

The Board argues that Kolasa violated a drug law and unlawfully possessed hydrocodone and morphine. Unauthorized possession of a controlled substance under § 195.202.1 is a felony under Missouri law. In order to prove a violation of § 195.202, a person must have: "(1) conscious and intentional possession of the substance, either actual or constructive; and (2) awareness of the presence and nature of the substance."[7]

Hydrocodone is a controlled substance.[8] So is morphine. [9] Kolasa's unlawful possession of these substances may not be inferred merely from the fact that the Med Dispense system states

[7] *State v. Anderson*, 386 S.W.3d 186, 190 (Mo.App E.D. 2012).
[8] Section 195.017.4(1)(a)(j).
[9] Complaint at ¶¶15-16.

that she removed them, and there is no record that Kolasa destroyed them. Kolasa testified that she had an off day with errors in documentation. Kolasa also testified that the Med Dispense machine made errors with regard to the times that drugs were removed. We find that testimony credible. Kolasa specifically testified that she destroyed the morphine pills, and we find that testimony credible. The Board has the burden of showing that Kolasa actually possessed these substances, apart from her duties as a nurse, via a drug screen or other evidence. This Commission is unwilling to attribute intentional possession of controlled substances to negligent conduct by a nurse. Kolasa therefore is not subject to discipline under § 335.066.2(1) and (14).

Subdivision (5) – Professional Standards and Honesty

Incompetency is a "state of being" showing that a professional is unable or unwilling to function properly in the profession.[10] Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing."[11] Gross negligence is a deviation from professional standards so egregious that it demonstrates a conscious indifference to a professional duty.[12] Fraud is an intentional perversion of truth to induce another, in reliance on it, to part with some valuable thing belonging to him.[13] It necessarily includes dishonesty, which is a lack of integrity or a disposition to defraud or deceive.[14] Misrepresentation is falsehood or untruth made with the intent and purpose of deceit.[15]

Based on the totality of the evidence presented, we cannot find that Kolasa took the hydrocodone and the morphine from Northland and attempted to cover up the theft by not

[10] *Albanna v. State Bd. of Reg'n for the Healing Arts*, 293 S.W.3d 423, 435 (Mo. 2009)
[11] *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo.App. E.D. 1988).
[12] *Id*. at 533.
[13] *State ex rel. Williams v. Purl*, 128 S.W. 196, 201 (Mo. 1910).
[14] MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 359 (11th ed. 2004).
[15] *Id*. at 794.

properly documenting the use of the drugs. We therefore do not find misconduct, fraud, or dishonesty.

Kolasa attached a patient's trach shield. Kolasa did so only after the patient had removed a ventilator tube and the patient's oxygen level had fallen to a dangerous level. Kolasa took this emergency action because the respiratory therapist did not arrive. We find that these actions were proper.

Kolasa gave patient G.M. insulin against doctor's orders. Kolasa gave patient T.D. 800 milligrams of Dilantin when the doctor ordered only 300 milligrams. Kolasa made mistakes with regard to these actions on October 26, 2008. A mistake, however, is not willful wrongdoing. We do not find misconduct.

The Board presented no expert evidence about the standards applicable to LPNs and controlled substance use, so we cannot find gross negligence.[16]

There is no cause for discipline under § 335.066.2(5).

Subdivision (12) – Professional Trust or Confidence

The Board argues that Kolasa violated a professional trust or confidence. Professional trust is reliance on the special knowledge and skills that professional licensure evidences.[17] It may exist not only between the professional and his clients, but also between the professional and his employer and colleagues.[18]

We find that there was no violation of professional trust. While Kolasa made some mistakes, there is no cause for discipline under § 335.066.2(12).

[16] *State Bd. of Reg'n for the Healing Arts v. McDonagh*, 123 S.W.3d 146, 158 n. 16 (Mo. 2003); *Tendai v. Missouri State Bd. of Reg'n for the Healing Arts*, 161 S.W.3d 358, 367 (Mo. 2005), overruled on other grounds by *Albanna v. State Bd. of Reg'n for the Healing Arts*, 293 S.W.3d 423, 435 (Mo. 2009); *Kerwin v. Missouri Dental Board*, 375 S.W.3d 219 (Mo.App. W.D.2012).

[17] *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943).

[18] *Cooper v. Missouri Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo.App. E.D. 1989).

Summary

Kolasa is not subject to discipline.

SO ORDERED on July 25, 2013.

\s\ Nimrod T. Chapel, Jr.
NIMROD T. CHAPEL, JR.
Commissioner